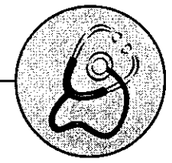
MEDICAL PLAN



Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly and Per Paycheck Premiums

	New West	Blue Choice	Traditional	Peak
Employee	$526/$263	$552/$276	$590/$295	$624/$312
Employee & spouse	$691/$345	$710/$355	$814/$407	$820/$410
Employee & children	$606/$303	$622/$311	$712/$356	$718/$359
Employee & family	$704/$352	$722/$361	$830/$415	$836/$418
Joint Core	$554/$277	$568/$284	$646/$323	$654/$327

NON-MEDICARE MEDICAL RATES (under age 65)

Monthly Premiums	New West	Blue Choice	Traditional	Peak
Retiree	$526	$552	$590	$624
Retiree & spouse	$691	$710	$814	$820
Retiree & children	$606	$622	$712	$718
Retiree & family	$704	$722	$830	$836
Retiree & Medicare spouse	$596	$612	$700	$706
Retiree & Medicare spouse and child	$626	$642	$736	$742

MEDICARE MEDICAL RATES (age 65+)

Monthly Premiums	New West	Blue Choice	Traditional	Peak
Medicare retiree	$182	$196	$218	$224
Medicare retiree & spouse	$392	$400	$454	$460
Medicare retiree & children	$335	$342	$386	$392
Medicare retiree & family	$413	$422	$480	$486
Medicare retiree & Medicare spouse	$347	$354	$400	$406
Medicare retiree & Medicare spouse & family	$372	$378	$430	$436

MEDICAL PLAN COSTS

	TRADITIONAL PLAN Administered by BCBS of MT	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Benefits		**In-Network Benefits**	**Out-of-Network Benefits**
Annual Deductible *(Applies to all services unless noted or a co-payment is indicated)*	$600/Member $1,800/Family New	$425/Member $850/Family New	Separate $550/Member Separate $1,100/Family
Coinsurance Percentages (% of allowed charges member pays) General Preferred Facility Services *(See pages 39-40 for a list of preferred/non-preferred facilities)* Non-Preferred Facility Services	25% 20% 35%	25%	35%
Annual Out-of-Pocket Maximums *(Maximum coinsurance paid in the year; excludes deductibles and copayments)*	Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
You pay deductible and coinsurance on allowable charges (see glossary on page 7).	Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*		
MEDICAL PLAN COSTS	**Member Coinsurance:**	**Member Coinsurance/Copayment:**	**Member Coinsurance:**
Hospital Inpatient Services*			
***Pre-certification of non-emergency hospitalization is strongly recommended & required by some plans - see plan descriptions**			
Room Charges	20% - 35%	25%	35%
Ancillary Services*	20% - 35%	25%	35%
Surgical Services*	20% - 35%	25%	35%
Hospital Outpatient and Surgical Center Services*	20% - 35%	25%	35%

ANNUAL SCHEDULE OF BENEFITS

BENEFIT YEAR 2009

MEDICAL PLAN SERVICES	TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
Physician/Professional Services (not listed elsewhere)			
Office Visits	25% (no deductible for first two non-routine office visits)	$15/visit (covers office visit charges only)	35%
Inpatient Physician Services*	25%	25%	35%
Lab/Diagnostic/Injectibles/Miscellaneous Charges*	25%	25% (no deductible on injectibles without an office visit)	35%
Emergency Services			
Ambulance Services for Medical Emergency	25%	$100 copay	$100 copay
Emergency Room *(If there is an inpatient emergency admission, see plan description for authorizing follow up care.)*	20%-35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)
Hospital Charges			
Professional/Ancillary Charges	25%	25%	25%
Urgent Care Services			
Facility/Professional Charges	25%	$25/visit	$25/visit
Ancillary - Lab/Diagnostic/Surgical Charges	25%	25%	25%
Maternity Services			
Hospital Charges*	20% - 35%	25%	35%
Physician Charges (including delivery, pre and post-natal office visits) and lab charges*	25%	0% (no deductible) with enrollment in prenatal program in first trimester of pregnancy; 25% otherwise	35%
Ultrasounds*	25%	25% (waived on first ultrasound if member enrolls in prenatal program as described above)	35%
Routine Newborn Care			
Inpatient Hospital Charges	20% - 35% (no deductible)	25% (no deductible)	35%
Preventive Services (see plan descriptions for what services are covered and when)			
Adult Exams and Tests	25% (no deductible) **Max:** 2 bone density tests/lifetime **Max:** $500 for colonoscopy, sigmoidoscopy, or proctoscopy	$15/visit (including specified labs) 0% (no deductible) for periodic mammograms 25% for periodic bone density scans, EKG sigmoidoscopies, double contrast barium enemas, proctoscopies & colonoscopies	35% (plan pays $75.00 for periodic mammograms - no deductible)
Adult Immunizations (such as Pneumonia and Flu)	$50 Max (no deductible)	$15 with office visit 25% (no deductible) without office visit up to $10	35%
Allergy Shots	25% (no deductible)	$15 with office visit 25% (no deductible) without office visit up to $10	35%
Child Checkups and Immunizations	25% (no deductible) 0% (no deductible for County Health Department through age 7)	$15/visit **Max:** Schedule recommended by US Department of Health & Human Services	35%
Mental Health Services			
Inpatient Services* **Max:** One inpatient day may be exchanged for two partial hospital days.	20% - 35% **Max:** 21 days *(No max for severe conditions)*	25% **Max:** 21 days/yr *(No max for severe conditions)*	35% **Max:** 21 days/yr *(No max for severe conditions)*
Outpatient Services			
With EAP counselor referral	25% **Max:** 40 visits/yr *(No max for severe conditions)*	$15/visit **Max:** 30 visits/yr *(No max for severe conditions)*	35% **Max:** 30 visits/yr *(No max for severe conditions)*
With NO EAP counselor referral	50% **Max:** 20 visits/yr *(No max for severe conditions)*	$15/visit **Max:** 30 visits/yr *(No max for severe conditions)*	35% **Max:** 30 visits/yr *(No max for severe conditions)*

ANNUAL SCHEDULE OF BENEFITS

BENEFIT YEAR 2009

MEDICAL PLAN SERVICES	TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
Chemical Dependency Services			
Inpatient Services* *(Inpatient services must be certified. Pre-certification is strongly recommended.)*	20%-35% **Max:** Dollar Limit**	25% **Max:** Dollar Limit**	35% **Max:** Dollar Limit**
Outpatient Services*			
With EAP counselor referral	25% **Max:** 40 visits and Dollar Limit**	$15/visit **Max:** Dollar Limit**	35% **Max:** Dollar Limit**
With NO EAP counselor referral	50% **Max:** 20 visits and Dollar Limit**	$15/visit **Max:** Dollar Limit**	35% **Max:** Dollar Limit**
Rehabilitative Services - Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy*			
Inpatient Services*	20% - 35% **Max:** 60 days/yr	25% **Max:** 60 days/yr	35% **Max:** 60 days/yr
Outpatient Services	20% - 35% **Max:** $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max:** 30 visits/yr	35% **Max:** 30 visits/yr
Alternative Health Care Services			
Acupuncture	25% (plus charges over $30/visit)	Not covered	Not covered
Naturopathic	25% (plus charges over $30/visit)	Not covered	Not covered
Chiropractic	25% (plus charges over $30/visit) **Max:** 25 visits in any combination	$15/visit **Max:** 20 visits/yr	35% **Max:** 20 visits/yr
Extended Care Services			
Home Health Care*	25% **Max:** 70 days/yr	$15/visit **Max:** 30 visits/yr	35% **Max:** 30 visits/yr
Hospice*	25% (20% - 35% if hospital-based) **Max:** 6 months	25% **Max:** 6 months	35% **Max:** 6 months
Skilled Nursing*	25% (20% - 35% if hospital-based) **Max:** 70 days/yr	25% **Max:** 30 days/yr	35% **Max:** 30 days/yr
Miscellaneous Services			
Disease Process Education & Dietary/Nutritional Counseling	20% - 35% **Max:** $250/yr	0% (no deductible) **Max:** $250/yr	35% **Max:** $250/yr
Durable Medical Equipment, Appliances, and Orthotics* *(Prior authorization required for amounts >$1,000)*	25% **Max:** $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max:** $100 for foot orthotics (per foot)	35% (not applied to out-of-pocket max) **Max:** $100 for foot orthotics (per foot)
PKU Supplies	25%	25% (no deductible)	35%
Obesity Management* *(All plans require prior authorization)*	25%	25% non-surgical only	Not covered
TMJ Treatment* *(All plans require prior authorization)*	25%	25% surgical only	Not covered
Infertility Treatment* *(All plans require prior authorization)*	25% 1 in-vitro attempt per lifetime	25% Max: 3 artificial inseminations/lifetime	Not covered
Bariatric Benefit* *(see page 16 for more details - requires prior authorization)*	25% **Lifetime Max:** $35,000	Not covered	Not covered
Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*	25%	25%	Not covered
Transplant Services (including out-of-state travel)*	• Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	$500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	

**Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

MEDICAL INSURANCE PLANS - 2009

Administered by:
Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • www.bluecrossmontana.com
New West Health Plan • 1-800-290-3657 or 457-2200 • www.newwesthealth.com
Peak Health • 1-866-368-7325 • www.healthinfonetmt.com

WHO IS ELIGIBLE?

Employees, Legislators, Retirees, COBRA members and their dependents (spouse, domestic partner, children) are eligible for the medical plan. Employees are required to be enrolled in medical coverage unless they waive the entire benefit package. For more information about dependent eligibility, see page 18.

CLICK ON IT!
Learn more about the participating providers by visiting the plan's web sites at:
www.bluecrossmontana.com
www.newwesthealth.com
www.healthinfonetmt.com

HOW TO DECIDE THE RIGHT PLAN FOR YOU

1. Read about each plan in the General Information section on this page.
2. Review/compare each plan's costs, deductibles and services in the Schedule of Benefits starting on page 10 or through the SOME information resource available on the MINE or benefits.mt.gov.
3. Review your typical health care needs compared with the structure of the plans.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 36-38.
5. Determine which plan will work best for your personal situation.
6. If you choose to change plans for the 2009 benefit year, indicate your choice on the *Individual/ Retiree Benefits Statement* or on-line as indicated on pages 4-5.

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice Plan**
- **New West Health Plan**
- **Peak Health Plan**

LIFETIME MAXIMUM

The lifetime maximum (the maximum the plan pays) per person on the plan is $2 million.

TRADITIONAL PLAN

The Traditional indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notices to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, they will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. Please verify a provider is currently participating by calling BCBS or checking their website.

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

Bariatric Benefit

This benefit is available only on the Traditional plan. To qualify, the member must be on the State plan for 18 months, have a body mass index over 40, participate in the *Why Weight* program (page 28) and meet medical necessity requirements for the procedure. For benefit coverage information, see pages 14 & 15.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 39 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West Health Plan, and Peak Health Plan are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in premium costs, providers and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required plan authorization is obtained).

In-Network Benefits

Anytime a network provider is used, the in-network (highest level of benefit) is applied. For a complete listing of all in-network providers including specialists, check the plan administrator's website or call their Customer Service number. An authorization is not required for the plan member to see an in-network specialist. Plan authorizations are required to see an out-of-network specialist and still receive the plan's in-network benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, without a required authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

To obtain an authorization to see an out-of-network provider from New West or Blue Choice plans, the member must contact the plan administrator directly.

New

Referrals for the Peak plan are obtained through your Primary Care Provider.

Major Plan Differences

The major difference in the managed care plans are the participating providers and premium costs.

Check which providers participate by visiting the plan websites listed on page 16.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 36-38 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, Havre, Libby, Miles City and now in Lewistown.

New

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and nearby communities.

MEDICAL PLAN COST COMPARISONS

This cost comparison shows how each medical plan would process the same service and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on pages 10 & 11. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.
*First two office visits are exempt from the deductible for this comparison.

			TRADITIONAL	MANAGED CARE PLANS	
Sample Services	**Allowable Charge**			**In-Network**	**Out-of-Network**
Office visits 1, 2, & 3 ($50 each)	**$150**	**You pay ➡**	**$75**	**$45**	**$150**
Copay costs				$45 ($15/each)	
Costs applied to deductible			$50*		$150
Coinsurance costs			$25		
Lab charges with office visit 1	**$75**	**You pay ➡**	**$75**	**$75**	**$75**
Copay costs					
Costs applied to deductible			$75	$75	$75
Coinsurance costs					
Specialist Visit (i.e. dermatologist)	**$200**	**You pay ➡**	**$200**	**$15**	**$200**
Copay costs				$15	
Costs applied to deductible			$200		$200
Coinsurance costs					
Preferred hospital inpatient	**$8,500**	**You pay ➡**	**$1,920**	**$2,350**	**$2,125**
Copay costs					
Costs applied to deductible			$275	$350	$125
Coinsurance costs			$1,645	$2,000**	$2,000**

**coinsurance out-of-pocket maximum